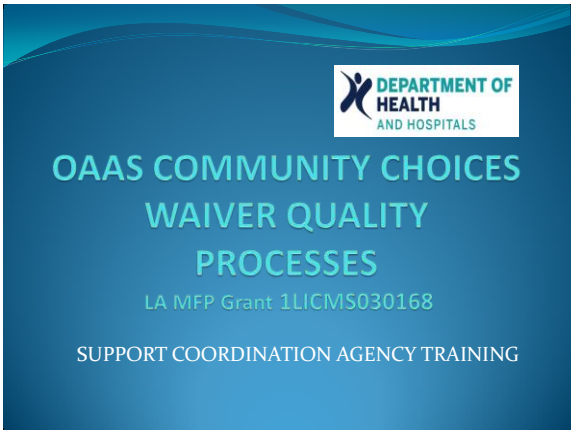


TRAINING OUTLINE

I. INTRODUCTION and LEARNING OBJECTIVES
II. CMS ASSURANCES and SC RESPONSIBILITIES
III. OAAS COMMUNITY CHOICES WAIVER PERFORMANCE MEASURES (PMs)
IV. OVERVIEW of SUPPORT COORDINATION MONITORING PROCESS
V. SC DOCUMENTATION & PROTOCOL

TRAINING OUTLINE

VI. SC RESPONSIBILITIES FOR LOC ELIGIBILITY DETERMINATION AND POC APPROVAL
VII. OAAS QUALITY REVIEW TOOL FOR LEVEL OF CARE/ PLAN OF CARE
VIII. ASSESSMENT & PLANNING REFERENCE GUIDES
IX. CRITICAL INCIDENT REPORTING: SC RESPONSIBILITIES
X. ACKNOWLEDGEMENTS
XI. ACRONYMS

OBJECTIVES

- To introduce learners to the CMS assurances and OAAS performance measures
- To illustrate to learners the essential role SCs play in promoting quality and complying with waiver assurances
- To introduce learners to the Support Coordination Monitoring process and review elements

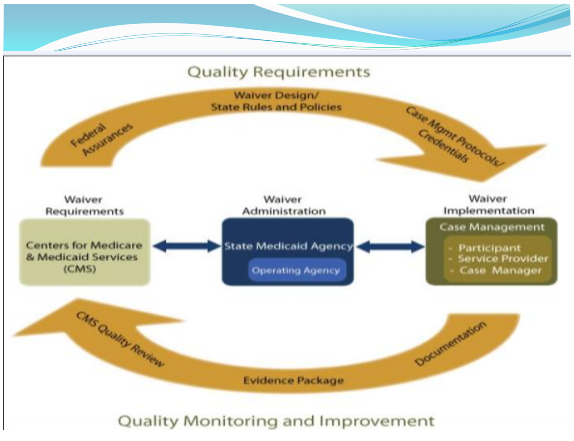
OBJECTIVES

- To provide learners with information on required documentation
- To introduce learners to the Level of Care Quality Review Process
- To introduce learners to the new plan of care approval process
- To emphasize mandated Critical Incident reporting responsibilities

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) ASSURANCES

HCBS WAIVER ASSURANCES

- 6 mandated assurances (requirements)
- Put into place by Congress
- Address quality of services



1. Administrative Authority: *Appendix A*
2. Level of Care: *Appendix B*
3. Qualified Providers: *Appendix* C
4. Service Plan (POC): *Appendix D*
5. Health and Welfare: *Appendix G*
6. Financial Accountability: *Appendix I*

Subassurances
Level of Care; Qualified Providers; Service Plan

- Operationalize CMS' interpretation of what the assurances mean
- Further define the assurances
- Ensure that states monitor the fundamental aspects of the program

IMPORTANT POINT

The assurances have an impact on your work each and every day. Much of what you are asked to do and particularly how you are asked to document what you do, ties back to the assurances.

ADMINISTRATIVE AUTHORITY (Appendix A)

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

LEVEL OF CARE (Appendix B)

The State demonstrates that it implements the processes and instrument(s) for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/DD.

3 LOC Subassurances:

a. LOC provided to prospective applicants
b. LOC reevaluation at least annually
c. LOC process and instruments applied appropriately

SC Role for the Level of Care Assurance

- Conduct timely level of care assessments/re-assessments
- Attend required level of care training sessions
- Maintain state mandated certification requirements

SERVICE PLAN = PLAN OF CARE (Appendix D)

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

5 Service Plan Subassurances:

a. Service Plans address all participants' assessed needs, including health and safety risk factors and personal goals
b. State monitors Service Plan development.

5 Service Plan Subassurances

(cont.)

c. Service Plans are revised at least annually and when participant's needs change.

d. Type, scope, amount, duration, and frequency of services are delivered as specified.

e. Participants are given choice: between waiver services and institutional care and between/among waiver services and providers.

As a Support Coordinator, you play a critical role in service planning, coordination, and implementation. What you do directly affects the health and welfare of waiver participants and their ability to live in their homes/communities.

QUALIFIED PROVIDERS (Appendix C)

The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

3 Qualified Providers Subassurances:

a. Providers meet required licensure/certification standards and other standards prior to service delivery.
b. State monitors non-licensed/non-certified providers.
c. Provider training is conducted and verified.

SC Role for the Qualified Providers Assurance

- Make sure that workers providing services meet the participant's needs
- Identify problems or issues with implementation of services and notify appropriate people in the provider agency, your agency, or the state to remedy or investigate the situation

SC Role for the Qualified Providers Assurance in Self-Direction

- Training and supporting participants in:
  - Preparing job descriptions
  - Recruitment strategies
  - Interviewing techniques
  - Supervision
  - Performance reviews
- Providing assistance when problems arise with workers

HEALTH AND WELFARE (Appendix G)

The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse neglect, and exploitation.

Critical Incident System

- What events are reported
- Who reports to whom
- Timeframes for reporting and investigating
- Who receives, evaluates, and investigates reports
- Process and timelines for informing the participant/family

Support Coordination Role for the Health and Welfare Assurance

- Get to know your participants and their environment/Build rapport
- Identify and document risks
- Make sure providers and workers understand what is expected of them
- Maintain regular communication; detect early warning signs
- Inform people of the right to be safe and how to report
- Help implement strategies for addressing and monitoring situations that arise
- Contribute to quality improvement

Important Point

Your role under the Health and Welfare assurance is one of astute observation, documentation, and action. Failure to meet the intent of this assurance – keeping participants safe – brings serious consequences.

FINANCIAL ACCOUNTABILITY (Appendix I)

The State Medicaid Agency pays only for services that are approved and provided, the cost of which does not exceed the cost of a nursing facility or institutional care on an aggregate basis.

WHY ASSURANCES?

The assurances were put into place by Congress to address the unique challenges of assuring the quality of services delivered to vulnerable persons living in their homes.

WHY ASSURANCES?

- There is not always someone there to keep an eye on care/services.
- Participants rely on many people for their care and safety without much coordination.
- People may be vulnerable and not know how to get help
- People may be afraid of losing their services or being put in a nursing home if they report problems.

How does DHH show CMS it is meeting the Assurances?

- **Performance Measures** for each Assurance/Subassurance
- DHH periodically informs CMS on progress in meeting the Performance Measures through detailed, data-specific **Evidence Reports.**

SC Quality Training Resource found at: http://hcbsassurances.org/

QUESTIONS?

EXAMPLES OF CCW PERFORMANCE MEASURES

Level of Care

***B.a.i.b.1*:** # and % of waiver participants who received an annual redetermination of eligibility within 12 months of their initial or last LOC evaluation.

***B.a.i.c.2*:** # and % of participants whose LOC determinations were made by a qualified evaluator.

Plan of Care (Service Plan)

D.a.i.d.1: # and % of participants who received all types of services specified in the service plan.

D.a.i.d.2: # and % of participants who received services in the amount, frequency, and duration specified in the service plan.

Health and Welfare

G.a.i.a.1: # and % of critical incident reviews/investigations that were completed within required timeframes.

G.a.i.a.2: # and % of participants who received the coordination and support to access health care services identified in the plan.

Qualified Providers

C.a.i.a.2: # and % of providers who meet licensure/certification requirements.

C.a.i.c.1: # and % of licensed waiver providers, by provider type, meeting training requirements.

Financial Accountability

I.a.1: # and % of waiver services provided to participants….on the date the service was reported as delivered

Administrative Authority

A.a.i.3: # and % of waiver offers that were appropriately made to applicants on the Request for Services Registry.

Why Performance Measures?

- Well-designed PMs become indicators of whether the state is meeting the assurances made to CMS in the approved 1915c waiver
- PMs drive the waiver's Quality Improvement Strategy (QIS)
- PMs form the basis of the evidence that DHH must provide to CMS to demonstrate we have met the assurances

WHY IS IT IMPORTANT FOR YOU TO BE AWARE OF THE CMS ASSURANCES AND CCW PERFORMANCE MEASURES?

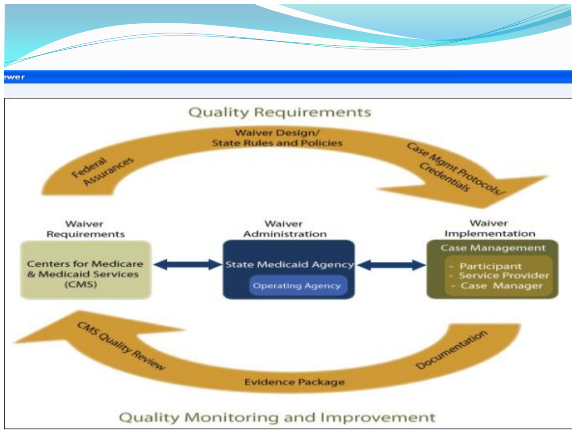
1. The Assurances have an impact on your work each and every day.
2. As a Support Coordinator, you play a key role in assuring that the HCBS Waiver works to meet the participant's needs and improve outcomes.
3. Much of what you are asked to do, and particularly how you are asked to document what you do, ties back to the Assurances.

How does this relate to Money Follows the Person (MFP) participants?

State Medicaid Agency for MFP must:

- Develop continuous quality improvement systems for HCBS
- Monitor the quality of HCBS services provided MFP participants
- Guarantee Health and Welfare in the community

This training has a direct and vital impact on several goals of the MFP.



QUESTIONS?

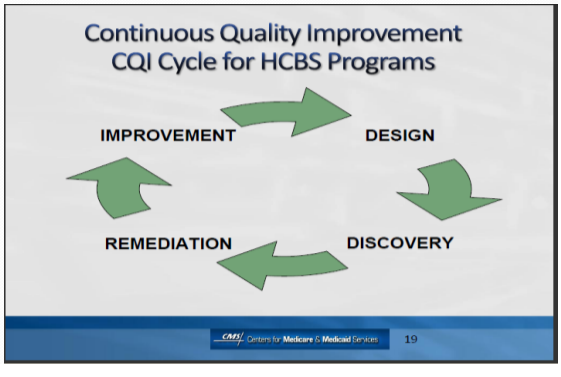
OVERVIEW of SUPPORT COORDINATION MONITORING PROCESS

Why is SC Monitoring so important?

- SC's perform a critical role in assuring the health and welfare of waiver participants
- SC Monitoring provides valuable information to determine how well an SC Agency is meeting the standards of care set by Louisiana and CMS

SCM also:

- Monitors adherence to state laws, regulations and agreement provisions
- Provides evidence towards meeting the CMS assurances
- Measures agency performance
- Is a standardized method for assessing performance within and across HCBS waivers



SCA Monitoring Components

- Participant Record Review
- Participant Visit/Interview
- Support Coordinator Interview
- SC Agency Review (record review at SCA and interview with SCA Director/Program Director/or Designee)

SC PERFORMANCE OUTCOMES

- Assessments
- Health and Safety Risks
- Participation in Planning
- Plan of Care Meets Needs & Preferences
- Plan of Care Service Initiation & Timelines
- Protection of Participant in Emergency
- Participant Choice
- Participant Needs Are Met
- Participants Are Safe

SC AGENCY PERFORMANCE OUTCOMES

- Qualified Staff
- Competent Support Coordinators
- Consistent/Stable Workforce
- Efficient/Effective Operation
- Continuous Improvement of Services and Outcomes

The Following Slides List the Nine Outcomes with the Corresponding Review Elements Which are Monitored through Participant Record Review

OUTCOME I
Assessments are accurate, complete and timely:

- Components of the assessment/reassessment are comprehensive
- There is a comprehensive assessment of participants' medication/health task regimens
- The assessment is performed by a qualified evaluator

OUTCOME II
Health and safety risks are identified and mitigated:

- Does the POC have strategies to address all risks identified in the assessment?
- Does the SC assess and mitigate risks throughout the year?

  (and document in the Support Coordination Documentation form [SCD])?

OUTCOME III
Participants are involved planning

The participant and those authorized to represent him are involved in planning to the fullest extent. Participants are given sufficient support and guidance in the planning process.

How do we know?

- Assessment, POC documentation& SCD provides evidence of participant/representative involvement.
- The POC is signed by the correct person(s).

OUTCOME IV A
The POC has strategies to address the participant's identified, assessed needs, goals, and preferences:

- Does the POC have strategies to address all needs identified in the assessment?
- Does the POC identify non-waiver services?
- Does the SC assess and address needs throughout the year?

  (and document in the SCD)?

OUTCOME IV B
The POC has strategies to address the participant's identified, assessed needs, goals and preferences:

- Does the POC include information about goals and preferences?
- Does the SC ensure that preferences are respected?

  (and document in the SCD?)

OUTCOME V
POCs and service initiation are up to date and timely:

- Does SC forward approved initial, annual, and updated POC 's to the provider within 3 days of approval?
- Does SC forward approved initial, annual, and updated POC's to the participant within 3 days of approval?

OUTCOME VI
Participants are protected in the event of an emergency

- Effective and current Emergency Plans are in place
- Effective and current Back-up Staffing Plans are in place
  - Does the SCD provide evidence that plans and agreements are kept up to date throughout the year?

OUTCOME VII
Participants have choice

- Participants have been informed and encouraged to exercise their freedom to choose:
  - Between institutional and community-based services
  - The waiver services which best meet their needs
  - Between all providers of waiver services
  - Between traditional and self-directed services
- Is there POC acknowledgement signature attest to FOC and is it signed by the right person?

OUTCOME VIII
Participants' needs are met

- **Support coordinators regularly review participant status to determine the effectiveness of the POC**
- **Support coordinators monitor service delivery**

Does the SCD provide evidence that all of the activities above are performed?

OUTCOME VIII
Participants' needs are met (continued):

- **Problems accessing POC services are clearly identified and addressed in a timely manner**
- **Plans of Care are updated when warranted by changes in participant needs**

Does the SCD provide evidence that all of the activities above are performed?

OUTCOME IX
Participants are safe

- **All Critical Incidents are identified and addressed**
- Does the SCD document evidence that participants are asked monthly about critical incidents ?
- Is incident reporting and resolution completed according to the timelines and processes described in the OAAS Critical Incident Policy?
- Does the Annual POC renewal include an annual assessment of critical incidents and strategies to address prevention of future incidents?

Snapshot of LA Record Review Tool with Corresponding Performance Measure

LA Outcome/ Performance Measure	Review Element	Documentation	Rating	
			Met	Not Met
Louisiana Outcome: Participants are protected in the event of an emergency. **CMS Health and Welfare Assurance Waiver Performance Measure:** Number and percent of participants with emergency and staffing back-up plans which continued an agreement signature by the responsible parties.	**RR 6.1** Emergency preparedness and response plans are in place in case of an emergency	RR 6.1.a. The participant's emergency preparedness and response plan identifies responsible parties and their roles, functions, and responsibilities for immediate implementation in the event of a natural disaster or other emergency.		
		RR 6.1.b. There is evidence that persons responsible for implementing the emergency preparedness and response plan have been fully informed and agree to carry out their identified roles, functions, and responsibilities as evidenced by their signature.		
		RR 6.1.c. There is documentation in the quarterly monitoring records that indicate the emergency preparedness and response plan is reviewed by/with whom?		
	RR 6.2 Staffing back-up plans are effective and appropriately implemented	RR 6.2.a. The participant's written back-up plan identifies responsible parties and their roles, functions, and responsibilities for immediate implementation in the event that a service worker cannot work when scheduled.		
		RR6.2.b. There is evidence that persons responsible for implementing the back-up plan have been informed and agree to carry out their identified roles, functions, and responsibilities.		
		RR6.2.c. There is documentation in the quarterly monitoring records that indicate the back-up staffing plan is reviewed by/with participant/family.		

SC MONITORING INTERPRETIVE GUIDELINES

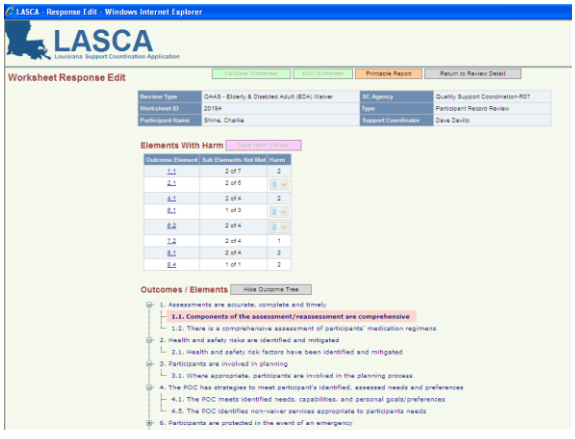
- Identifies the SC Monitoring outcomes with related Review Elements/Sub-Elements
- Identifies review documents relevant to each Review Element/Sub-Element
- Identifies related citations
- Identifies guidelines for compliance
- Provides a valuable reference document for reviewers and SC Agencies
- Promotes standardized application of requirements

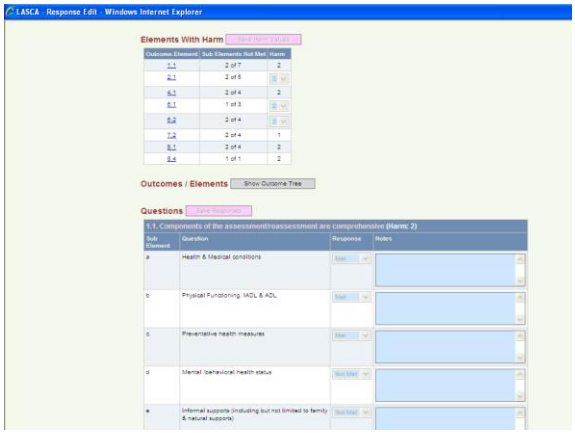
SCORING

1. Whether an element is met or not met
2. Whether harm or the potential for harm resulted when an element was not met
3. Whether there is likelihood of a system failure given the prevalence of elements not met or the number of participants affected by a given element

LASCA

- Louisiana Support Coordination Application (LASCA)
- Automated Monitoring System
- Accessed by DHH Staff
- Review Event Tracker





QUESTIONS?

OAAS SUPPORT COORDINATION DOCUMENTATION (SCD) & PROTOCOL (SCDP)

Why? As stated in the HCBS Waiver Application:

Quality Improvement:

The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants .....

"The State further assures…..

- ……. that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem".

Quality Reporting to CMS:

- HCBS 1915(c)Waiver Programs require a detailed Quality Improvement Strategy (QIS)
- The QIS must include performance measures valid to each of the federal assurances (42 CFR §441.302)
- Three of the six assurances are the primary responsibility of the waiver "operating agency"-OAAS
  - **Level of Care (LOC)**
  - **Service Plan (POC)**
  - **Health & Welfare (H & W)**

Quality Reporting to CMS: (continued)

- **The QIS must include:**
  - **Performance measures (PM's)** for every CMS assurance and subassurance with:
    - Data Source
    - Frequency of report generation and analysis
    - Processes for individual and systemic remediation of noncompliance
  - **Evidence must be collected, aggregated, analyzed and remediated for each waiver year** and then reported to CMS in an Evidentiary Based Report

So how is evidence collected for meeting the waiver assurances?

- **There are three main data sources for the waiver performance measures:**

1. The service prior authorization data base
2. The Online Tracking of Incidents System (OTIS)
3. The SC Monitoring (SCM)Participant Record Review which is comprised of two parts:
   - **Review of the Plan of Care**
   - **Review of the ongoing Support Coordination Documentation (SCD)**

SCD Components

1. Monthly Contact Documentation

2. Interim Documentation

3. Quarterly Service Delivery Monitoring and Risk Assessment

Monthly Contact Documentation

- Purpose: Provides prompts to identify and address changes, problems, risks

- Related Assurances: Service Plan, H&W, LOC

OAAS Support Coordination Documentation (SCD)

Monthly Contact Documentation

DEPARTMENT OF HEALTH AND HOSPITALS

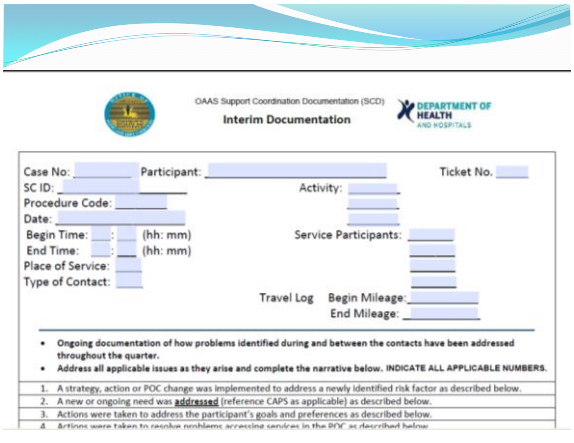
Case No: _____ Participant: _____ Ticket No. ____
SC ID: _____ Activity: _____
Procedure Code: _____
Date: _____
Begin Time: ___:___ (hh: mm)
End Time: ___:___ (hh: mm)
Place of Service: _____
Type of Contact: _____
Service Participants: _____
Travel Log Begin Mileage: _____
End Mileage: _____

Answer each question, record the participant's/responsible representative's (RR) answers and describe in the narrative.

	YES	NO
1. Were there any changes to medications or treatments since last contact? If YES, describe below.	☐	☐
2. Were there any changes in who is available to give the participant's medication or treatments since last contact? If YES, describe below.	☐	☐
3. Were there any major changes in the person's life that have affected or could affect their health	☐	☐

Interim Documentation

- Purpose: Provides a systematic method to address issues during and between contacts
- Related Assurances: Service Plan, Health & Welfare



OAAS Support Coordination Documentation (SCD)

Interim Documentation

DEPARTMENT OF HEALTH AND HOSPITALS

Case No: _____ Participant: _____ Ticket No. ____
SC ID: _____ Activity: _____
Procedure Code: _____
Date: _____
Begin Time: ___:___ (hh: mm)
End Time: ___:___ (hh: mm)
Place of Service: _____
Type of Contact: _____
Service Participants: _____
Travel Log Begin Mileage: _____
End Mileage: _____

- **Ongoing documentation of how problems identified during and between the contacts have been addressed throughout the quarter.**
- **Address all applicable issues as they arise and complete the narrative below. INDICATE ALL APPLICABLE NUMBERS.**

1. A strategy, action or POC change was implemented to address a newly identified risk factor as described below.
2. A new or ongoing need was **addressed** (reference CAPS as applicable) as described below.
3. Actions were taken to address the participant's goals and preferences as described below.
4. Actions were taken to resolve problems accessing services in the POC as described below.

QUARTERLY SERVICE DELIVERY MONITORING & RISK ASSESSMENT

- **Purpose:**
- **1. Assess, address, and document all problems with service delivery**
- **2. Reassess and update emergency plans, and back-up staffing plans**
- **3. Reassess and summarize risks and risk-mitigation for the quarter.**

Basis for Quarterly Service Monitoring

Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

- **CCW Performance Measures**
- D.a.i.d.1 Number and percent of participants who received all types of services specified in the service plan.
- D.a.i.d.2 Number and percent of participants who received services in the amount, frequency and duration specified in the service plan.

OAAS Support Coordination Documentation (SCD)

DEPARTMENT OF HEALTH AND HOSPITALS

QUARTERLY
SERVICE DELIVERY MONITORING AND RISK ASSESSMENT

Monthly Progress Note/Fax/Mail

Case No: _____ Ticket No. _____
Participant: _____ Activity: _____
SC ID: _____ Procedure Code: _____
Date: _____ Other Code: _____

Begin Time: ___:____ (hh: mm) Service Participants: _____
End Time: ___:____ (hh: mm) _____
Place of Service: ____ _____
Type of Contact: ____ _____
Entered: ___/_ __/_____
Modified: ___/_ __/_____ Travel Log
Sent: ___/_ __/_____ Begin Mileage: _____ _____
End Mileage: _____

I. GENERAL QUESTIONS:

- Answer all questions below for each service that the participant receives.
- For all "NO" answers, please describe in the narrative section how it was addressed.

Review in the home:	Yes	No	N/A
1. Plan of Care (current & approved) in the binder?			
2. OAAS Participant's Rights & Responsibilities Form (OAAS-RF-08- 003) in the binder?			
3. Blank Critical Incident Forms in the binder?			
4. Did the PAS provider keep required service logs/time sheets according to requirements?			
5. Is the Support Coordination Agency's toll free number available?			
6. Is the Provider's toll free number available?			
7. Is the OAAS Waiver Help Line toll free number available?			
Ask the Participant or Responsible Representative (RR):			

Assessing and Addressing Problems with Service Delivery

Section I. General Questions

- Applies to Personal Assistance Service provider expectations
- Applies to assistive devices identified in the POC
- Assess through in-home observation and asking the participant
- Documents dates that Service Plan was sent to Provider and participant
- Address all negative findings and document in the Narrative

Quarterly Service Delivery Monitoring & Risk Assessment

Section II. Quarterly Risk Assessment

- This section prompts the SC to :
- Reassess and update emergency plans and back-up staffing plans
- Reassess and summarize risks and risk mitigation for the quarter.

Assessing and Addressing Problems with Service Delivery

Section III. Monitoring of Ongoing Services

- Evaluate the delivery of ongoing services for the prior quarter.
- This section applies only to PAS and ADHC.
- Review service delivery documentation for potential service delivery problems
- Discuss last quarter's service delivery with the participant or responsible representative.
- Determine whether all ongoing services in the POC were delivered in the amount, frequency, and duration specified in the service plan.

Assessing and Addressing Problems with Service Delivery

Section III. (continued):

- Determine the reason(s) why services were not delivered according to the POC
- Select codes for all reasons that apply within the quarter
- If during the quarter an unacceptable reason occurred (code 07 or 08) select the applicable remediation code
- Document all details of problem identification and resolution in the Narrative Section.

Assessing and Addressing Problems with Service Delivery

Section IV. Monitoring All Types of Services Delivered

- Occurs during the final quarter of the POC or month of discharge:
- Evaluate whether all types of services in the POC were received
- For each service type specified in the POC which was **NOT** delivered during the POC year, check applicable code(s)
- Enter supporting details in the Narrative Section.

How does the SCD benefit Support Coordinators?

- Provides a guide for asking all of the required, key questions for monthly and quarterly contacts.
- Provides a structured format to gain comprehensive information and effectively coordinate care and services.

(continued)

How does the SCDP benefit Support Coordinators?

(continued)

- Collected information is in a format which covers many Review Elements of the SC to aid agency compliance with state and federal regulations.
- Forms are designed to prompt SCs to ask the right questions and use critical thinking to determine what comes next.

QUESTIONS?

SC RESPONSIBILITIES FOR LOC ELIGIBILITY DETERMINATION AND POC APPROVAL

Delegation of Level of Care and Service Plan Review in the CCW:

- **From the waiver document Appendix A- Waiver Administration and Operation-Use of Contracted Entities:**

- *"**Support coordinators** - Support coordinators enrolled in Medicaid to serve participants in the Community Choices waiver **perform operational functions for level of care evaluation and re-evaluation …. and for review of participant service plans….."***

What This Means…….

- **Delegated to Support Coordinator Agencies:**
- ***Level of Care Evaluation***
  - *MDS-HC Assessment by SC*
  - *LOC determination by SC Supervisor*
- ***Review of Participant Plans of Care***
- Plan of Care (POC) Development by SC
  - Plan of Care review and approval by SC Supervisor
  - Submittal to the Data Contractor for prior authorization of services
  - Submittal to regional office if admission criteria is not met

New with the Community Choices Waiver

1. SC Agencies submit approvals directly to the data contractor.
2. The responsibility for timely submission rests entirely on the SC agency.
3. The SC agency has autonomy to manage their internal procedures in order to meet compliance and avoid sanctions.

OAAS Oversight of the Process

As described in the CC waiver document:

- **A retrospective review of Medicaid enrolled support coordinators** in their performance of level of care evaluation and service plan review will occur on an annual basis
- **Will utilize a representative sample record review** with performance measures described in the Level of Care, Service Plan and Health & Welfare Quality Improvement Strategies.

OAAS Oversight of the Process

(continued)

- Data with one hundred percent representativeness is available from the Medicaid data contractor for measures of timeliness.
- The timeliness data will be analyzed and utilized by regional OAAS staff on a monthly basis to request and monitor corrective action.
- The state-wide report of discovery, remediation and improvement activities for level of care and service plan review will also be analyzed and acted upon by OAAS and Medicaid.

Are there any POC and LOC determinations which are <u>not</u> sent directly to the data contractor?

Yes, any POC which does <u>not</u> meet the criteria for admission or continued admission. CRITERIA:

MUST:

- Meet Medicaid financial eligibility
- Meet nursing facility level of care
- Reside in this state
- Have no interruption in services for a period of 30 consecutive days as a result of the recipient not receiving and/or refusing Waiver services

Are there any POC and LOC determinations which are not sent directly to the data contractor?

(Continued) MUST:

- Health, safety and welfare of the individual must be assured through the provision of CC Waiver services within the individual's cost effectiveness.
- Cooperate in the eligibility determination process or in the performance of the CPOC.
- Maintain a safe and legal home environment.
- Must be cost effective to serve the individual in the CC Waiver.

What to do if admission criteria is not met?

1. In instances when a support coordination agency is unable to resolve problems with service plan implementation or health and welfare assurances they shall contact the OAAS regional office (RO) staff who will offer technical assistance towards resolution.
2. If discharge criteria still applies after step 1., gather all evidence which supports discharge criteria.
3. Submit to the OAAS regional office.

These two CCW performance measures drive the process

1. Number and percentage of waiver participants who received an annual redetermination of eligibility within 12 months of their initial or last LOC evaluation.
2. Number and percent of participants whose service plans were updated as warranted, on or before waiver participant's annual review date.

What is the SC Supervisory LOC/POC Approval?

- The processes of LOC eligibility determination, need assessment, resource allocation and care planning are inseparable. The assessment and planning data must correlate before either can be approved.
- A **certified SC Supervisor** must determine whether the LOC assessment and the Care Planning have been performed correctly.
- This is done through use of the ***OAAS LOC/POC Quality Review Tool***

(continued)

How is it performed?

- **Both** the SC performing the MDS-HC and the SC Supervisor determining the LOC/POC Approval **must be certified by OAAS in MDS-HC Assessment and Care Planning.**
- **The SC must:**
  - Perform a face-to-face MDS-HC
  - Perform or delegate data entry
  - Obtain the Resource Utilization Group designation
  - Develop a POC according to OAAS Care Planning Policy

(continued)

How is it performed?

(continued)

The Support Coordination Supervisor must:

- **Utilize the OAAS Quality Review Tool LOC Section** to determine whether the MDS-HC is **Complete**, followed **Correct** process, was **Coded** correctly with information which **Correlates** with all other sections of the MDS-HC, electronic notebook entries and the information in the POC.
- **Utilize the OAAS Quality Review Tool POC Section** to determine whether the POC correlates with the MDS-HC and **includes all criteria included in the review tool**.

What date is the SC Supervisory LOC/POC Approval?

- If the SC Supervisor determines that the LOC/POC is correct according to OAAS process, then the SC Supervisor may submit approval to the Data Contractor for authorization of the participants services.
- **The SC Supervisory LOC/POC Approval Date is the**:
  - **Date the SC Supervisor submits the approved LOC/POC signature page and with all required pages to the Data Contractor**
  - Until electronic POC is available submission is by email

Due Dates for Annual SC Supervisory LOC/POC Approval

- The **expiration date** of the current plan of care always determines the submittal due date of the next Annual SC Supervisory LOC/POC Approval.
  - Expiration Date is: the date on which the existing plan will expire (first day of no services).
- **The submittal due date to the Data Contractor is 14 calendar days before the expiration date.**
  - Example: A POC which expires on 12/15/2011 must be submitted by COB on 12/1/2011 or it is late.

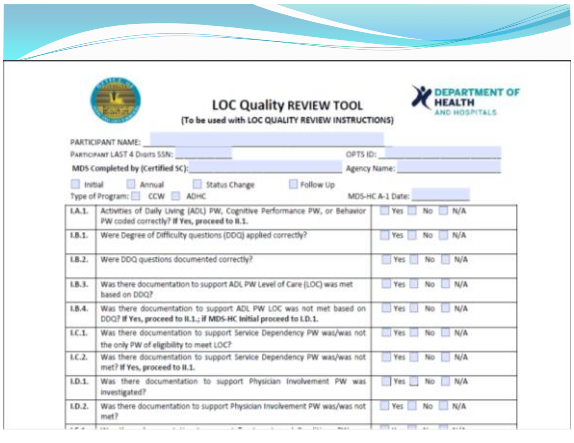
QUESTIONS?

OAAS LEVEL OF CARE/PLAN OF CARE QUALITY REVIEW TOOL

MDS-HC Assessment,
Level of Care (LOC) Determination, &
Plan of Care (POC) Completion

OAAS LOC/POC Quality Review Tool

- Component 1 – LOC Quality Review
- Component 2 – POC Quality Review



LOC Quality REVIEW TOOL
(To be used with LOC QUALITY REVIEW INSTRUCTIONS)

DEPARTMENT OF HEALTH AND HOSPITALS

PARTICIPANT NAME:
PARTICIPANT LAST 4 Digits SSN: _____ OPTS ID: _____
MDS Completed by (Certified SC): _____ Agency Name: _____
☐ Initial ☐ Annual ☐ Status Change ☐ Follow Up
Type of Program: ☐ CCW ☐ ADHC MDS-HC A-1 Date: _____

I.A.1.	Activities of Daily Living (ADL) PW, Cognitive Performance PW, or Behavior PW coded correctly? **If Yes, proceed to II.1.**	☐ Yes ☐ No ☐ N/A
I.B.1.	Were Degree of Difficulty questions (DDQ) applied correctly?	☐ Yes ☐ No ☐ N/A
I.B.2.	Were DDQ questions documented correctly?	☐ Yes ☐ No ☐ N/A
I.B.3.	Was there documentation to support ADL PW Level of Care (LOC) was met based on DDQ?	☐ Yes ☐ No ☐ N/A
I.B.4.	Was there documentation to support ADL PW LOC was not met based on DDQ? **If Yes, proceed to II.1.; if MDS-HC Initial proceed to I.D.1.**	☐ Yes ☐ No ☐ N/A
I.C.1.	Was there documentation to support Service Dependency PW was/was not the only PW of eligibility to meet LOC?	☐ Yes ☐ No ☐ N/A
I.C.2.	Was there documentation to support Service Dependency PW was/was not met? **If Yes, proceed to II.1.**	☐ Yes ☐ No ☐ N/A
I.D.1.	Was there documentation to support Physician Involvement PW was investigated?	☐ Yes ☐ No ☐ N/A
I.D.2.	Was there documentation to support Physician Involvement PW was/was not met?	☐ Yes ☐ No ☐ N/A

Section I.A.1.

Determine if MDS-HC Met LOC:

I.A.1.

Pathway(s) of Eligibility Met with:

- Activities of Daily Living (ADL) Pathway
- Cognitive Performance Pathway
- Behavior Pathway

Section I. B.1. – B.4.

If the ADL, Cognitive Performance, and the Behavior Pathways Are Not Met Consider Degree of Difficulty Questions (DDQ) for LOC Determination

I.B.1.

DDQ CRITERIA APPLIED DEPENDS ON THE TYPE OF ASSESSMENT:

- Initial Assessment

OR

- Reassessments – Annual, Status Change, or Follow Up

I.B.2.

- Must be documented correctly.

I.B.3. and I.B.4.

- Document in the MDS-HC Notebook DDQ applied and evidence used to support ADL PW LOC met or not met based on the response to questions, observations and/or comments.

Section I.C.1. – C.2.

Service Dependency Pathway

- Used only for Reassessments (Annuals, Status Changes and Follow-Ups)
- Identify individuals with a start of care date on or before 12/01/2006 **AND** had no break in services

I.C.1.

- SC have to contact OAAS Regional Office to verify start of care date and no break in services

I.C.2.

- Identify Supporting Documentation in the MDS-HC Notebook

Section I.D.1. – I.F.2.

TABLE 1

Use for the Review of Physician Involvement, Treatments & Conditions, and Skilled Rehabilitation Pathways.

MDS-HC Item	*Short Description*	*MDS-HC Score*
J.1.u.	Pneumonia	1 or 2
N.2.a.	Pressure Sores	3 or 4
P.1.f.	Physical Therapy	≥ 45 min
P.1.g.	Occupational Therapy	≥ 45 min
P.1.h.	Speech Therapy	≥ 45 min
P.2.b.	Respirator	1, 2 or 3
P.2.c.	Other Respiratory Treatments	1, 2 or 3
P.2.g.	Dialysis	1, 2 or 3
P.2.i.	IV infusion – Peripheral	1, 2 or 3
P.2.m.	Tracheostomy care	1, 2 or 3
P.2.o.	Occupational Therapy	1, 2 or 3
P.2.p.	Physical Therapy	1, 2 or 3

Table 1

Section I.D.1 – D.2.

Physician Involvement Pathway

- One day of physician visits **AND** at least 4 new order changes both occurring in the last 14 days

OR

- At least 2 days of physician visits **AND** at least 2 new order changes both occurring in the last 14 days

I.D.1.

Evaluate/Investigate Other Medical Documentation

- Hospital Discharge Summary
- Home Health Folder contains Physician Orders and POC (Form 485-486)

I.D.2.

Identify Supporting Documentation in the MDS-HC Notebook

Section I.E.1 – E.2.

Treatments and Conditions Pathway

- Stage 3-4 pressure sore(s) last 14days
- IV feedings last 7 days
- IV medications last 14days
- Daily trach care, suctioning, or respirator/vent usage last 14days
- Pneumonia last 14 days with ADL/IADL or restorative nursing care needs
- Daily respiratory care last 14days by qualified professional
- Daily insulin injections **AND** 2 or more order changes in last 14days
- Peritoneal or hemodialysis in last 14 days

I.E.1.

Evaluate/Investigate Other Medical Documentation

- Hospital Discharge Summary
- Home Health POC/Physician Orders (Form 485-486)
- OT/PT Progress Notes
- Physician Orders

I.E.2.

Identify Supporting Documentation in the MDS-HC Notebook

Section I.F.1 – F.2.

Skilled Rehabilitation Therapies Pathway

- At least 45 minutes of active Physical Therapy, Occupational Therapy and/or Speech Therapy given in the last 7 days

OR

- At least 45 minutes of active Physical Therapy, Occupational Therapy and/or Speech Therapy scheduled for the next 7 days ("look forward period")

I.F.1.

Evaluate/Investigate Other Medical Documentation

- Hospital Discharge Summary
- Home Health POC/Physician Orders (Form 485-486)
- OT/PT Progress Notes
- Physician Orders

I.F.2.

Identify Supporting Documentation in the MDS-HC Notebook

Section II.1.

MDS-HC Complete

Every Item Has An Answer

II.1.

Review Every Required Field for Completeness - Item, Letter Number, Signature, Title, and/or Date) for omissions in documentation.

Section III.1. – 2.

MDS-HC Correct

Accurate Observations and Information

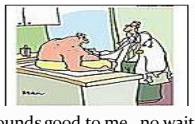
III.1.

Use Accurate Observations and Information:

- For look back period (i.e. Look back last 3 days for ADLs, except bathing which is the last 7 days, or unless otherwise specified as 30 days, 90 days, etc.)
- Observations/interviews made during visit/telephone calls.
- Home Health, Therapy, or Service Provider paper work in home.

III.2.

Documentation in the MDS-HC, MDS-HC Notebook, and the POC reflect accuracy in observations and information.



Sounds good to me…no wait that is my I Pod.

Section IV.1. – 2.

MDS-HC Coding

Correctly Coded Per Guidelines

IV.1.

- Scales and assessment data coded according to guidelines.
- MDS-HC should match the MDS-HC Notebook and POC.

IV.2.

- Must be coded correctly before correlation or it will not make sense.

- Codes/Correlation – Ask yourself : Does the mental picture make sense?

Yes,.. I am independent in decision making.

Section V.1.

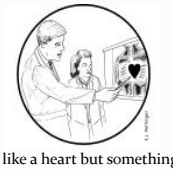
MDS-HC Correlation

Does the Individual "picture" make sense

- Does functional picture correlate to coded levels in cognition and communication?
- Do meds support/correlate to diseases/conditions? Is there any effect of the meds and/or disease on physical functioning (ADL/IADL)?
- Does functional picture correlate with clinical issues (nutrition, skin dental)?
- What is being provided by informal/formal support to meet identified levels of assistance? Does level of support correlate to any affected mental health/mood or behavior issues?

V.1.

All sections of the MDS-HC must match or the mental picture will not make sense.



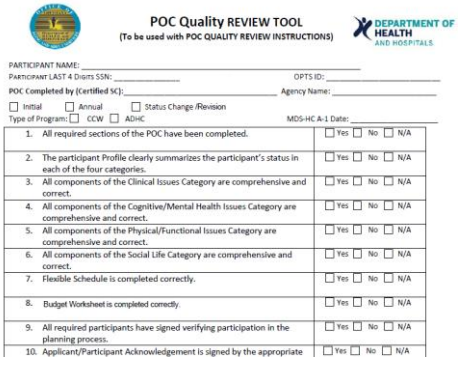
Looks like a heart but something is very wrong.

Correlation Guide

1. **ADL/IADL-cognition/communication**
2. **Medication-diseases-IADL/ADL**
3. **IADL/ADL-clinical issues (nutrition, skin, dental)**
4. **Social supports-service utilization-mental health**

Section	1	2	3	4
ADL/IADL	X	X	X	X
Cognition/Communication	X			
Medications		X		
Diseases		X		
Clinical Issues			X	
Social Supports				X
Service Utilization				X
Mental Health/Mood/Behavior				X

POC QUALITY REVIEW TOOL



POC Quality REVIEW TOOL
(To be used with POC QUALITY REVIEW INSTRUCTIONS)

DEPARTMENT OF HEALTH AND HOSPITALS

PARTICIPANT NAME: _____
PARTICIPANT LAST 4 Digits SSN: _____ OPTS ID: _____
POC Completed by (Certified SC): _____ Agency Name: _____
☐ Initial ☐ Annual ☐ Status Change /Revision
Type of Program: ☐ CCW ☐ ADHC MDS-HC A-1 Date: _____

1. All required sections of the POC have been completed.	☐ Yes ☐ No ☐ N/A
2. The participant Profile clearly summarizes the participant's status in each of the four categories.	☐ Yes ☐ No ☐ N/A
3. All components of the Clinical Issues Category are comprehensive and correct.	☐ Yes ☐ No ☐ N/A
4. All components of the Cognitive/Mental Health Issues Category are comprehensive and correct.	☐ Yes ☐ No ☐ N/A
5. All components of the Physical/Functional Issues Category are comprehensive and correct.	☐ Yes ☐ No ☐ N/A
6. All components of the Social Life Category are comprehensive and correct.	☐ Yes ☐ No ☐ N/A
7. Flexible Schedule is completed correctly.	☐ Yes ☐ No ☐ N/A
8. Budget Worksheet is completed correctly.	☐ Yes ☐ No ☐ N/A
9. All required participants have signed verifying participation in the planning process.	☐ Yes ☐ No ☐ N/A
10. Applicant/Participant Acknowledgement is signed by the appropriate	☐ Yes ☐ No ☐ N/A

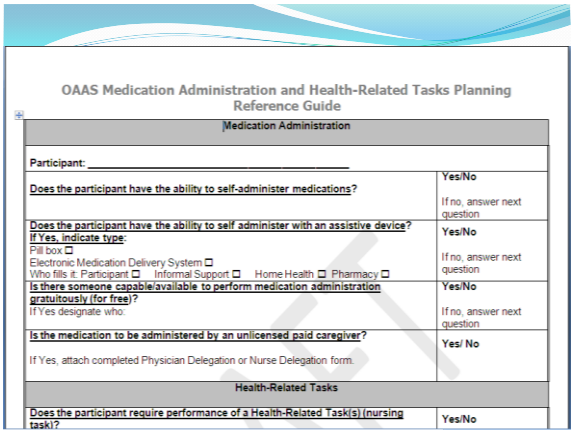
It is not mandatory to keep copies of the LOC & POC Quality Review Tools in the Record.

- However, the **quality review process** described in the LOC & POC Quality Review Tool Instructions is the exact process which will be followed by the regional monitors during SC Monitoring to determine whether the LOC & POC were completed correctly.
- **The same process must be followed by the SC Supervisors in order to achieve compliance during the SC Monitoring.**

QUESTIONS?

ASSESSMENT & PLANNING REFERENCE GUIDES

- Medication Administration and Health-Related Tasks
- CIR Analysis and Risk Assessment
- CC Waiver Risk Assessment & Referral Screening Tool
- Change in Status Checklist & Decision-Making Guide

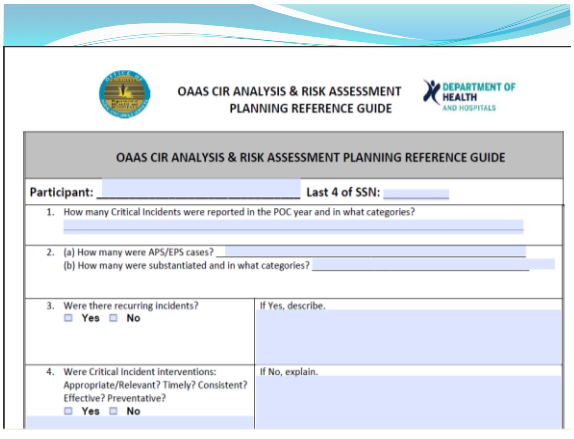


OAAS Medication Administration and Health-Related Tasks Planning Reference Guide

Medication Administration	
Participant: _____	
Does the participant have the ability to self-administer medications?	**Yes/No** If no, answer next question
Does the participant have the ability to self administer with an assistive device? **If Yes, indicate type:** Pill box ☐ Electronic Medication Delivery System ☐ Who fills it: Participant ☐ Informal Support ☐ Home Health ☐ Pharmacy ☐	**Yes/No** If no, answer next question
Is there someone capable/available to perform medication administration gratuitously (for free)? If Yes designate who:	**Yes/No** If no, answer next question
Is the medication to be administered by an unlicensed paid caregiver? If Yes, attach completed Physician Delegation or Nurse Delegation form.	**Yes/ No**
Health-Related Tasks	
Does the participant require performance of a Health-Related Task(s) (nursing task)?	**Yes/No**

Purpose: To document assessment & analysis of meds/health-related tasks and identify needs requiring inclusion in POC

Benefits: Systematic, standardized prompts for accurate planning that provide data for Service Plan and Health and Welfare Assurances



OAAS CIR ANALYSIS & RISK ASSESSMENT PLANNING REFERENCE GUIDE

DEPARTMENT OF HEALTH AND HOSPITALS

OAAS CIR ANALYSIS & RISK ASSESSMENT PLANNING REFERENCE GUIDE

Participant: _____ **Last 4 of SSN:**

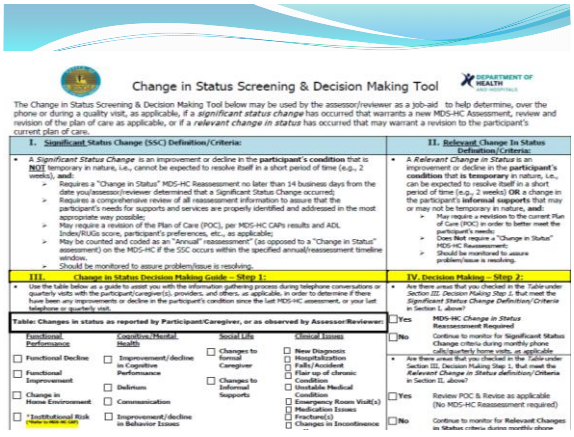
1. How many Critical Incidents were reported in the POC year and in what categories?

2. (a) How many were APS/EPS cases? _____
   (b) How many were substantiated and in what categories? _____

3. Were there recurring incidents? ☐ Yes ☐ No	If Yes, describe.
4. Were Critical Incident interventions: Appropriate/Relevant? Timely? Consistent? Effective? Preventative? ☐ Yes ☐ No	If No, explain.

Purpose: To document assessment & analysis of critical incidents and risks and identify needs requiring inclusion in POC

Benefits: Systematic, standardized prompts for accurate planning that provide data for Service Plan and Health and Welfare Assurances



Change in Status Screening & Decision Making Tool

The Change in Status Screening & Decision Making Tool below may be used by the assessor/reviewer as a job-aid to help determine, over the phone or during a quality visit, as applicable, if a *significant status change* has occurred that warrants a new MDS-HC Assessment, review and revision of the plan of care as applicable, or if a *relevant change in status* has occurred that may warrant a revision to the participant's current plan of care.

I. Significant Status Change (SSC) Definition/Criteria:

- A *Significant Status Change* is an improvement or decline in the **participant's condition** that is **NOT** temporary in nature, i.e., cannot be expected to resolve itself in a short period of time (e.g., 2 weeks), **and:**
  - Requires a "Change in Status" MDS-HC Reassessment no later than 14 business days from the date you/assessor/reviewer determined that a Significant Status Change occurred;
  - Requires a comprehensive review of all reassessment information to assure that the participant's needs for supports and services are properly identified and addressed in the most appropriate way possible;
  - May require a revision of the Plan of Care (POC), per MDS-HC CAPs results and ADL Index/RUGs score, participant's preferences, etc., as applicable;
  - May be counted and coded as an "Annual" reassessment" (as opposed to a "Change in Status" assessment) on the MDS-HC if the SSC occurs within the specified annual/reassessment timeline window.
  - Should be monitored to assure problem/issue is resolving.

II. Relevant Change In Status Definition/Criteria:

- A *Relevant Change in Status* is an improvement or decline in the **participant's condition** that is **temporary** in nature, i.e., can be expected to resolve itself in a short period of time (e.g., 2 weeks) **OR** a change in the participant's **informal supports** that may or may not be temporary in nature, **and:**
  - May require a revision to the current Plan of Care (POC) in order to better meet the participant's needs;
  - Does **Not** require a "Change in Status" MDS-HC Reassessment;
  - Should be monitored to assure problem/issue is resolving.

III. Change in Status Decision Making Guide – Step 1:

- Use the table below as a guide to assist you with the information gathering process during telephone conversations or quarterly visits with the participant/caregiver(s), providers, and others, as applicable, in order to determine if there have been any improvements or decline in the participant's condition since the last MDS-HC assessment, or your last telephone or quarterly visit.

Table: Changes in status as reported by Participant/Caregiver, or as observed by Assessor/Reviewer:

Functional Performance	Cognitive/Mental Health	Social Life	Clinical Issues
☐ Functional Decline	☐ Improvement/decline in Cognitive Performance	☐ Changes to formal Caregiver	☐ New Diagnosis
☐ Functional Improvement	☐ Delirium	☐ Changes to Informal Supports	☐ Hospitalization
☐ Change in Home Environment	☐ Communication		☐ Falls/Accident
☐ *Institutional Risk (Refer to MDS-HC QRP)	☐ Improvement/decline in Behavior Issues		☐ Flair up of chronic Condition
			☐ Unstable Medical Condition
			☐ Emergency Room Visit(s)
			☐ Medication Issues
			☐ Fracture(s)
			☐ Changes in Incontinence

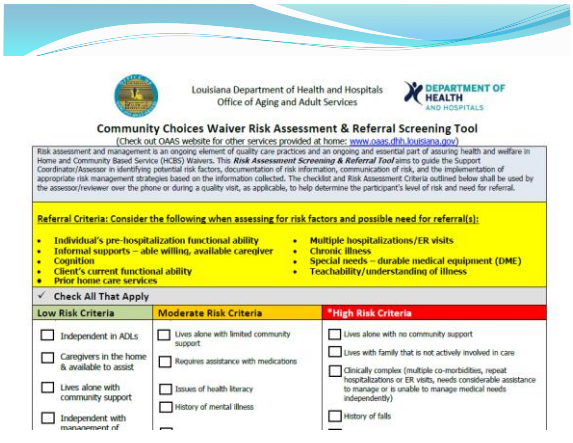
IV. Decision Making – Step 2:

- Are there areas that you checked in the *Table* under *Section III. Decision Making Step 1* that meet the *Significant Status Change Definition/Criteria* in Section I, above?
  - ☐ Yes — MDS-HC *Change in Status* Reassessment Required
  - ☐ No — Continue to monitor for Significant Status Change criteria during monthly phone calls/quarterly home visits, or applicable
- Are there areas that you checked in the *Table* under Section III. Decision Making Step 1, that meet the *Relevant Change in Status definition/Criteria* in Section II, above?
  - ☐ Yes — Review POC & Revise as applicable (No MDS-HC Reassessment required)
  - ☐ No — Continue to monitor for Relevant Changes in Status criteria during monthly phone

Change in Status Checklist & Decision-Making Guide

Purpose:

1. To provide methodical guidance in determining (via telephone or person-to-person contact) whether a **Significant Change in Status** or **Relevant Change in Status** has occurred.
2. To provide guidance on when a reassessment MDS-HC and/or review and update of POC is warranted.



Louisiana Department of Health and Hospitals
Office of Aging and Adult Services

DEPARTMENT OF HEALTH AND HOSPITALS

Community Choices Waiver Risk Assessment & Referral Screening Tool

(Check out OAAS website for other services provided at home: www.oaas.dhh.louisiana.gov)

Risk assessment and management is an ongoing element of quality care practices and an ongoing and essential part of assuring health and welfare in Home and Community Based Service (HCBS) Waivers. This ***Risk Assessment Screening & Referral Tool*** aims to guide the Support Coordinator/Assessor in identifying potential risk factors, documentation of risk information, communication of risk, and the implementation of appropriate risk management strategies based on the information collected. The checklist and Risk Assessment Criteria outlined below shall be used by the assessor/reviewer over the phone or during a quality visit, as applicable, to help determine the participant's level of risk and need for referral.

Referral Criteria: Consider the following when assessing for risk factors and possible need for referral(s):

- **Individual's pre-hospitalization functional ability**
- **Informal supports – able willing, available caregiver**
- **Cognition**
- **Client's current functional ability**
- **Prior home care services**
- **Multiple hospitalizations/ER visits**
- **Chronic illness**
- **Special needs – durable medical equipment (DME)**
- **Teachability/understanding of illness**

✓ Check All That Apply

Low Risk Criteria	Moderate Risk Criteria	*High Risk Criteria
☐ Independent in ADLs	☐ Lives alone with limited community support	☐ Lives alone with no community support
☐ Caregivers in the home & available to assist	☐ Requires assistance with medications	☐ Lives with family that is not actively involved in care
☐ Lives alone with community support	☐ Issues of health literacy	☐ Clinically complex (multiple co-morbidities, repeat hospitalizations or ER visits, needs considerable assistance to manage or is unable to manage medical needs independently)
☐ Independent with management of	☐ History of mental illness	☐ History of falls

CC Waiver Risk Assessment & Referral Screening Form

Purpose

1. To provide organized guidance in identifying potential risk factors, documentation of risk information, communication of risk, and implementation of appropriate risk management strategies.
2. To assist in identifying the participant's need for referral to address risk factor(s).

NOTE:

- These forms are intended to be used as planning aids.
- Through SC Monitoring, Regional Office staff will be reviewing all documentation to ensure that the processes of assessing, identifying, addressing, and documenting participants' risks/strategies/referrals are accurately and effectively performed.

QUESTIONS?

CRITICAL INCIDENT REPORTING & OTIS

Support Coordinator Responsibilities and How to Meet Them

Critical Incident Reporting/Resolution is Based on CMS Requirements

Waiver Performance Measure:

***G.a.i.a.1*: # and % of critical incident reviews/investigations that were completed within required timeframes.**

Process:

- Closure reports will be generated and analyzed quarterly
- Regional offices will track untimely closures and work with SC agencies on remediation & improvement
- **Results of each year will be reported to CMS**

Purpose of this Section:

- To inform SC's and Supervisors of all resources available for achieving compliance with Critical Incident Reporting (CIR) policy
- To discuss best management practices for achieving compliance
- To emphasize key points in the CIR process
- To emphasize collaboration with the regional office
- To notify SC agencies of the consequences of poor compliance

Critical Incident Timelines: (page one)

Waiver Incident Reporting Process Flow Chart

Participant or Family/ Direct Service Provider/Support Coordinator

Critical Incident (CI)				
Initial Action	**Participant or Family/ Direct Service Provider/Support Coordinator:** 1. Learns of critical incident and initiates appropriate actions to protect participant from harm 2. Abuse, neglect and exploitation must also be reported to APS/EPS/CP immediately			**IMMEDIATELY**
	Participant or Family	**Direct Service Provider (DSP)**	**Support Coordinator (SC)**	
Initial Reporting	• Report critical incidents immediately to the DSP and/or SC	• Notify the SC Agency within 2 hours of discovery AND • Send written report within 24 hours of discovery	• *Only when SC discovers CI: Contact DSP within 2 hours of discovery*	**WITHIN TWO HOURS**
			• Enters incident into W-OTIS by close of next business day after notification	**BY CLOSE OF NEXT BUSINESS DAY**
Preliminary Follow-up		• Submits written update to SC on CIR Form by close of 3rd business day after initial report		**BY CLOSE OF THIRD BUSINESS DAY**

Critical Incident Timelines: (page two)

(PAGE 2)	Participant or Family	Direct Service Provider (DSP)	Support Coordinator (SC)	
			• Enters Follow Up Case Note into W-OTIS by close of sixth business day after initial report	**BY CLOSE OF SIXTH BUSINESS DAY**
Until Closure		• Follows up and takes actions to address CI in conjunction with participant and SC • Cooperates with the investigation • Submits updates to SC as necessary until resolution	• Continues to follow up with DSP, participant as necessary • Updates OTIS case notes	**UNTIL CLOSURE BY THE REGIONAL WAIVER OFFICE**
Upon Closure			• Sends Participant Summary Letter to participant & DSP	**WITHIN FIFTEEN DAYS AFTER REGIONAL OFFICE HAS CLOSED CASE**

Compliance Begins with Correct SC Agency Communication and Policy

There must be agency procedures in place which ensure the following:

1. There are assigned SC agency staff on every business day to **monitor incoming** agency faxes and emails of Written Critical Incident Reports & Written Follow-up Reports from DSPs.
2. **That these reports are forwarded to an assigned, on-duty SC on the same business day with an accurate date & time of receipt.**

Compliance Begins with Correct SC Agency Communication and Policy

There must be agency procedures in place which ensure the following:

3. **There is an accurate record(log) of verbal notifications by DSPs** for instances when DSPs exercise the option to notify verbally within 2 hours and send the written report within 24 hours of discovery.

NOTE: **Answering services must collect the same information for after- hours notifications**

Compliance begins with correct agency communication and policy

There must be agency procedures in place which ensure the following:

4. When an SC agency staff or answering service **receives a call which informs of an emergency situation then the assigned or on-call SC must contact the DSP staff to advise and assist in any way necessary to assure participant safety.**
5. Designated staff must be available each and every business day to **ensure that incoming CIR reports or verbal notifications get to an on-duty SC no later than the same business day received.**

Compliance begins with correct agency communication and policy

There must be agency procedures in place which ensure the following:

6. When an **SC discovers a critical incident** they must :

- **Notify** the DSP agency within 2 hours of discovery,
- **Enter** the CIR into OTIS by close of next business day
- **Send a copy** to the provider at the time it is entered into OTIS.

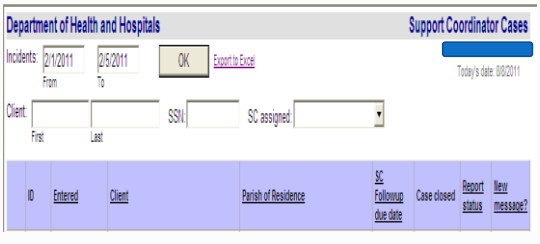
2 Major Resources for Compliance with CIR Policy are Found on the OAAS Website:

1. **Links to all current CIR training materials, forms and policies are posted on the "OTIS Resources" webpage.**

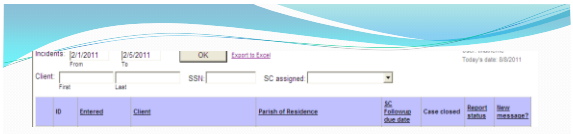
2. **A link to the "Support Coordination Case List" report is also found on the "OTIS Resources" webpage.**

Resources Available for Compliance with CIR Policy: Support Coordination Case List Link

Resources Available for Compliance with CIR Policy: Support Coordination Case List Link

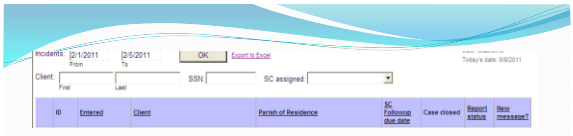


- **USE NUMBER ONE:**
- **<u>Participant Incident Assessment</u>**: If you are working on a participant's POC and you need to know the number and type of incidents they have had in the past 6 months,12 months etc.:
  - Enter the desired date range
  - Enter the participants name or social security number
  - Hit "OK"
  - This will produce a list of incident ID numbers for the requested time period for an individual participant.



USE NUMBER TWO:
Meeting reporting timelines for your own caseload or monitoring timeline performance of your staff.

- SO WHAT <u>ARE</u> THE THREE REPORTING TIMELINES FOR SC'S?



- **So what do I need to track and how often to be compliant?**

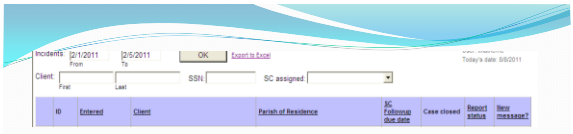
1. Each business day and according to your specific agency practice, <u>find out if any new CIR's have been reported for your caseload.</u>
2. Enter your new cases by the close of the next business day for all new CIRs and perform responsibilities described in the OAAS CIR policy.
3. Each business day, pull the list or lists which fall under your responsibility.

IMPORTANT NOTE #1:

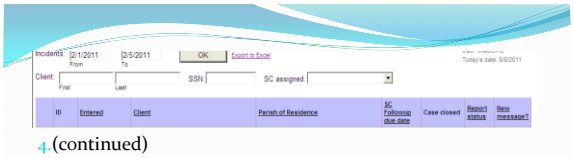
- Do not forget to enter "SC Assigned" when you first enter a CIR.
- If you forget, it will not show up in your tracking list and you could miss your due date.

IMPORTANT NOTE #2:

- Each business day when you pull your CIR list: **Respond to all messages from the Regional office by COB.**



4. **Meet your "SC Follow-up Due Date" as follows:**
   - Review your SC Follow-up due dates pending
   - For Any CIRs that are three business days away from your SC due date and you have still not received the DSP Written Follow-up do the following:
     - Notify the DSP agency that it's overdue and you still need it
     - Notify the DSP that if you don't get it by 6th business day you are required to report to the regional office
     - Request any verbal info they can give but DO NOT ENTER the event "Follow-up Received" based on a verbal report.

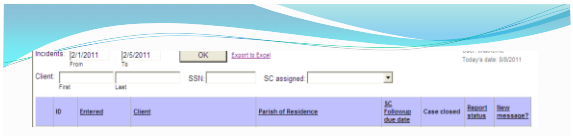


4.(continued)
   - IF you do not receive a written follow up from the DSP by the 6th business day (due date for your follow-up case note) call the regional office to report it and document this in your follow-up case note
   - Enter any verbal follow-up that you have received in your follow-up case note at that time.
   - Although a "Follow-up Received" event is required for incident closure **do not enter a date and time for "Follow-up Received until you receive a written follow up report from the provider.**

What is Written Follow-up from the DSP?

Written Follow-up is an update of information received since the initial report and includes all actions taken by the provider to resolve the incident and prevent future recurrence.

- Written Follow-up must include an *OAAS Fall Analysis and Action Form* when a fall occurred during direct services.
- When a fall occurred outside of direct service delivery the DSP must still collaborate with the SC for participant safety and send Written Follow-up which describes actions which the provider will take to prevent future falls.



More About Written Follow-up from the DSP

1. What if nothing is changed or no actions were taken since the initial report?

   ANSWER: The DSP must state this in writing by the follow-up due date.

2. What if the SC notified the DSP of an incident?

   ANSWER: The DSP must send a written report by the 3rd business day after notification.

Is a Written Follow-up report required from the DSP when a participant has died?

If the initial DSP report contained all required information * **and** the DSP has addressed all questions/concerns from the SC and regional office, in these instances **only :**

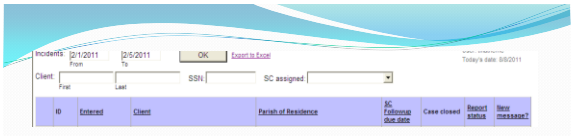
The SC may use the "Written Report Received" date/time as the "Follow-up Received" date/time.

* **When, where, how, and who was with the person when they died.**

What Will Happen to the Providers Who Don't Send You Follow-up?

1. OAAS CIR Policy states that DSPs are to send written follow-up by the close of 3rd business day after 1st report.
2. SCs contact the DSP if they do not get that report by the 3rd business day (get a verbal report , request written report, & document in OTIS)
3. If the DSP still doesn't send it by the 6th business day, then SC notifies Regional office, who sends a warning notice to the provider.

(continued)



What Will Happen to the Providers Who Don't Send You Follow-up?

(continued)

4. If the DSP has still not sent written follow-up by time of CIR closure, the regional office will enter an event into OTIS which states:

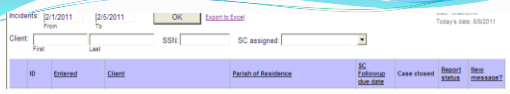
   "Written Report not received from DSP"

5. DSPs who do not respond to a warning(s) from the Regional Office **will be reported to Health Standards Section along with the supportive evidence.**

- **Two More Tips:**

1. If you need to print a long incident list select:
   - Export to Excel: Select PDF: Then Print
2. Track the **Report Status** column for the date that the RO has closed the event. **Once closed by RO:**

- Hit the Print button on the Case Notes Page-this will print the Participant Summary
- **Send a copy to the participant and DSP within 15 calendar days of closure.** This will be tracked through SC Monitoring.



Also keep in mind:

- We are facilitating a process that encourages DSP's to meet their CIR responsibilities which in turn makes it easier for SC's to meet theirs.
- Once you have reported the providers non-compliance to the RO on the 6th business it becomes RO responsibility to get correct action from the DSP prior to incident closure.

This Training Module is to Supplement (not replace)Training Materials on the OTIS Resource Page

PRACTICE SITE VS LIVE SITE

Please make sure that when you enter a "DUMMY" incident case into OTIS, that it is the PRACTICE SITE!

Please make sure that when you enter a "REAL" incident into OTIS, that it is the LIVE SITE!

CONSEQUENCES OF NON-COMPLIANCE

- **RECOUPMENT OF FUNDS**
- **CESSATION OF LINKAGES**
- **REMOVAL FROM THE FREEDOM OF CHOICE LIST**
- **DECERTIFICATION AS A SC AGENCY FOR OAAS-ADMINISTERED HCBS**

QUESTIONS?

ACKNOWLEDGEMENTS

- HCBS Quality Requirements and Quality Monitoring and Improvement Cycle

CMS Training for Case Managers
University of Southern Maine
Muskie School of Public Service

www.hcbsassurances.org

ACKNOWLEDGEMENTS

- Continuous Quality Improvement CQI Cycle for HCBS Programs
  www.cms.hhs.gov

- CMS HCBS National Quality Enterprise presentation titled: *Meaningful Use of Data: Medicaid HCBS Monitoring and Reporting Strategies.*

ACRONYMS

- ADHC – Adult Day Health Care
- ADL – Activities of Daily Living
- CCW – Community Choices Waiver
- CIR – Critical Incident Report
- CMIS – Case Management Information System
- CMS – Centers for Medicare and Medicaid Services
- CQI – Continuous Quality Improvement
- DHH – Department of Health and Hospitals
- DDQ – Degree of Difficulty Questions
- DDRI – Design/Discovery/Remediation/Improvement
- H&W – Health and Welfare
- HCBS – Home and Community-based Services
- LASCA – Louisiana Support Coordination Application
- LOC – Level of Care

ACRONYMS

- MDS-HC – Minimum Data Set – Home Care
- MFP – Money Follows the Person
- NF – Nursing Facility
- OAAS – Office of Aging and Adult Services
- OTIS – Online Incident Tracking System
- PAS – Personal Assistance Services
- PM – Performance Measure
- POC – Plan of Care
- PW – Pathway
- QIS – Quality Improvement Strategy
- SC – Support Coordination or Support Coordinator
- SCA – Support Coordination Agency
- SCD – Support Coordination Documentation
- SCM – Support Coordination Monitoring